MEDICAL EXPENSE STATEMENT

List amounts you paid in 2005 for qualified medical expenses that were not reimbursed to you. You may be required to provide documentation from the provider of the service for expenses claimed on your Property Tax Reduction application.

CLAIMANT'S NAME_____**COUNTY**_____

_____

MEDICAL INSURANCE – 1 YEAR PREMIUM

Include only insurance premiums for policies that cover medical care.

Name of Payee	Amount Paid
1	$
2	
3	
	Total

NAME OF DOCTORS

Name of Payee	Amount Paid
1	$
2	
3	
4	
	Total

PRESCRIPTION DRUGS

Name of Payee	Amount Paid
1	$
2	
3	
4	
	Total

HOSPITAL, AMBULANCE, NURSING HOME ETC

Name of Payee	Amount Paid
1	$
2	
3	
	Total

Please use the back for additional listings.	**Total from back $**
GRAND TOTAL – Transfer amount to line 13 of the property tax reduction application	**$**

UNDER PENALTY OF PERJURY, I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED HEREIN IS TRUE, CORRECT, AND COMPLETE.

_____ _____

SIGNATURE OF CLAIMANT OR REPRESENTATIVE DATE

Name of Payee	Amount Paid
1	$
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	**TOTAL**

LODGING – (Maximum lodging expense is $50. per night)

	TOTAL

MEDICAL MILEAGE:

January 1, 2005 – August 31, 2005			
FROM	**TO**	**MILES**	**X .15 PER MILE**
FROM	**TO**	**MILES**	**X .15 PER MILE**
FROM	**TO**	**MILES**	**X .15 PER MILE**
FROM	**TO**	**MILES**	**X .15 PER MILE**
September 1, 2005 – December 31, 2005			
FROM	**TO**	**MILES**	**X .22 PER MILE**
FROM	**TO**	**MILES**	**X .22 PER MILE**
FROM	**TO**	**MILES**	**X .22 PER MILE**
			Total $
TRANSFER TOTAL TO FRONT OF FORM			**GRAND TOTAL $**